COMMUNITY CONNECTIONS
REFERRAL FORM

1. Parent/Guardian Name_____ Mother Father Other:_____
First Last
Home Phone:_____ Alt. Phone:_____

2. Parent/Guardian Name_____ Mother Father Other:_____
First Last
Home Phone:_____ Alt. Phone:_____

Address:_____

City:_____ Zip code:_____ County:_____

Is English primary language spoken at home? Y / N If no, what is?_____ Is an interpreter needed? Y / N

All Child(ren) Name(s)	Date of Birth	School/ Grade	Gender	Spec. Ed. Status
			M / F	Y / N
			M / F	Y / N
			M / F	Y / N
			M / F	Y / N
			M / F	Y / N
			M / F	Y / N
			M / F	Y / N

AREAS OF CONCERN:

_____ Housing
_____ Transportation
_____ Food/Nutrition
_____ Health Insurance
_____ Employment
_____ Financial Assistance
_____ Citizenship
_____ ESL classes/Adult Education
_____ Multicultural resources
_____ Post War/ Trauma (PTSD)
_____ Childcare
_____ Parenting Skills

_____ Parent/Child Conflict
_____ Sibling Conflict
_____ Abuse – Physical/Sexual/Emotional
_____ School Problems /Behavior/Delinquency
_____ Chemical Use/Abuse
_____ Parental Separation/Divorce
_____ Mental/Physical Illness
____ Special Education
_____ Grief & Loss
_____ Absent Family Member(s)/Reunification
_____ Infant/Preschool needs
_____ Other:_____

OTHER PROFESSIONALS INVOLVED WITH FAMILY (Ex. Teacher, para, public health nurse, Spec. Ed. Case Manager, etc.)

_____

In order for the Community Resource Specialist to contact this family, parent(s) must agree to the referral.

HAVE THE PARENTS GIVEN THEIR PERMISSION REGARDING THIS REFERRAL? Y / N

REFERRED BY:_____ DATE:_____

SCHOOL DISTRICT: _____ SCHOOL:_____

Fax Referrals to: Community Connections : 763-422-7232 **For Questions Contact: 763-422-7227**
(Due to data privacy concerns, referrals should not be communicated via e-mail.)

Staff Assigned: _____ **I & R:** ____ **Direct Service:** ____ **Open:** _____ **PSOG:** ____